JHPIEGO
An Affiliate of Johns Hopkins University
WORKING TO IMPROVE THE HEALTH OF WOMEN AND FAMILIES THROUGHOUT THE WORLD

Improving Safe Motherhood through Shared Responsibility and Collective Action

The Maternal and Neonatal Health Program
Accomplishments and Results, 2002—2003

Maternal & Neonatal Health

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United States Agency for International Development

Maternal & Neonatal Health

The Maternal and Neonatal Health (MNH) Program is committed to saving mothers' and newborns' lives by increasing the timely use of key maternal and neonatal health and nutrition practices. The MNH Program is jointly implemented by JHPIEGO, the Johns Hopkins University/Center for Communications Programs, the Centre for Development and Population Activities, and the Program for Appropriate Technology in Health.
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For 30 years, JHPIEGO has been committed to improving the health of women and families throughout the world. JHPIEGO is dedicated to excellence—ensuring quality service delivery and strengthening human capacity development. The organization's work spans a continuum of client-centered care—from prevention to treatment—in reproductive health and family planning, HIV/AIDS, maternal and neonatal health, and cervical cancer. As an affiliate of Johns Hopkins University, JHPIEGO draws on the University's extensive expertise to develop innovative responses to the challenges of today's reproductive health needs.
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December 2003

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Photo by Erwin Ochoa, MNH/Honduras

A woman and newborn at Hospital Roberto Suazo Cordova in La Paz (Region 2), Honduras (September 2003).

In its first 5 years, the Maternal and Neonatal Health (MNH) Program has influenced the expansion of the safe motherhood movement both globally and in more than 20 countries. Emphasizing shared responsibility and collective action, the Program promotes an integrated strategic approach focusing on strengthening clinical service delivery, generating awareness and demand for high-quality services through behavior change and social mobilization, and facilitating the development of a supportive policy environment. For its articulation of international evidence-based standards in partnership with the World Health Organization (WHO) and other lead donors and for its innovative programming in Africa, Asia, and Latin America, the MNH Program is regarded and respected internationally as a leader in safe motherhood.

Achievements and results are evident across MNH Program countries. The Program is contributing to improved quality of services, increased political support for safe motherhood, empowered and informed communities, and increased use of the range of essential maternal and newborn care services, including care from a skilled provider at birth. A variety of Program tools and approaches are used and promoted by MNH Program partners such as UNICEF, UNFPA, and Columbia University's Averting Maternal Death and Disability (AMDD) program. Due to its technical excellence and responsiveness, the Program enjoys sound partnerships globally and at the country level and is well positioned to continue to expand the safe motherhood agenda well beyond 2004.

MNH Program interventions support the development of skilled providers and help to create an enabling environment within the healthcare system while at the same time mobilizing stakeholders and linking informed communities to safe motherhood services.

Program Strategy

The Maternal and Neonatal Health Program is dedicated to ensuring that women and newborns survive pregnancy, childbirth, and the postpartum period. The Program focuses on interventions known to have the greatest impact on reducing maternal and newborn mortality—including the provision of skilled care. Although many factors contribute to skilled care, the single most critical intervention in saving the lives of women and newborns is the presence of a skilled provider during childbirth and the immediate postpartum/newborn period.

Promoting the concept of collective action for birth preparedness/complication readiness in the antenatal, intrapartum, and immediate postpartum/newborn periods, the Program works with a range of players—policymakers, providers, communities, families, and women themselves—to ensure that the necessary ingredients are in place to increase the use of skilled providers at birth. Central to the MNH Program strategy is a broad package of essential maternal and newborn care (EMNC) interventions that are evidence-based and build on global lessons learned about what works to save the lives of mothers and newborns. Program interventions support the development of skilled providers and help to create an enabling environment within the healthcare system while at the same time mobilizing stakeholders and linking informed communities to safe motherhood services.

Partnerships for Success

Since 1998, the MNH Program has been actively engaged with a range of partners both globally and across countries to promote improved maternal and newborn survival. In Latin America, Asia, and Africa, the Program—in partnership with 10 global donors and more than 50 international and local nongovernmental organizations (NGOs)—has responded to the challenges inherent in safe motherhood programming with innovation and a commitment to excellence.

Partnerships are central to the Program's success. Through close collaboration at the country level and through participation in international bodies such as the Roll Back Malaria Working Group for Malaria During Pregnancy and the Healthy Newborn Partnership, the Program is able to share experiences as well as tools and approaches with a range of organizations and associations. Dialogue and shared learning enhances the reach of safe motherhood approaches and promotes the efficient use of available resources.

In all countries, the MNH Program has worked at the national level with ministries of health to set the stage for improved care through the revision of national policies, norms, and protocols based on international evidence-based standards and guidelines.

Confidence in the Program's technical excellence is evident through the many organizations working with the Program and using its tools and approaches. Work with Columbia University's AMDD program has extended the MNH Program's competency-based training approach and the development of skilled trainers for emergency obstetric care to Afghanistan, Bangladesh, Bhutan, India, Nepal, and Pakistan. For instance, WHO's recent EMNC knowledge and clinical skills update, using the MNH Program's training materials and competency-based training approach, extended skills to 18 obstetricians, midwives, and other practitioners representing six African countries, including Ethiopia, Mozambique, and Nigeria. A few of the Program's regional experts conducted the WHO knowledge and skills update as well as a recent UNICEF-supported training in West Africa for improved antenatal care.

USAID's commitment to the safe motherhood agenda and confidence in the MNH Program are evident in their increasing investment in the Program over time. In 1998, the Program was working in seven countries. By 2002–2003, the Program had more than doubled to encompass 12

country programs—Afghanistan, Bolivia, Burkina Faso, Egypt, Guatemala, Haiti, Honduras, Indonesia, Nepal, Tanzania, the Regional Centre for Quality of Health Care (RCQHC) in Uganda, and Zambia—and four countries where the Program is working to advance the management of malaria during pregnancy—Ghana, Kenya, Nigeria, and Rwanda.

The MNH Program's SAFE study in Indonesia led to the issuance of a government resolution incorporating the prevention of PPH into the national health strategy.

Results

Through sustained commitment over time, the MNH Program—with USAID investment and through active partnerships—is achieving significant results. In all countries, the MNH Program has worked at the national level with ministries of health, other government counterparts and institutions, and NGO partners to set the stage for improved care through the revision of national policies, norms, and protocols (PNPs) for reproductive health and safe motherhood, using international evidence-based standards and guidelines.

The MNH Program actively supports the implementation of these PNPs through regional and district-level programming. In Tanzania, where the National Malaria Control Program reports that coverage of intermittent preventive treatment (IPT) for the prevention and management of malaria during pregnancy increased from 29 percent in 2001 to 65 percent in 2003, the Program played a lead role in defining and rolling out the country's National Package of Reproductive and Child Health Interventions, including the use of IPT. In Bolivia, the Program made a significant contribution to the adoption of the Ministerial Resolution updating safe motherhood practices in accordance with the international standards in *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors (MCPC)*—a joint publication of WHO and JHPIEGO, through the MNH Program. Most recently, the MNH Program's safety, acceptability, feasibility, and effectiveness (SAFE) study in Indonesia, targeting community-based distribution of misoprostol for the prevention of postpartum hemorrhage (PPH) in home births, led to the issuance of a government resolution incorporating the prevention of PPH into the national health strategy.

The Program's investment in enhancing provider competence and site strengthening has resulted in the increased use of evidence-based practices such as monitoring labor with the WHO-standard partograph, limiting the routine use of episiotomy, consistently using active management of the third stage of labor, establishing skin-to-skin contact between mothers and their newborns, and immediate breastfeeding. In West Java, Indonesia, for example, the routine use of active management of the third stage of labor resulted in a reduction of postpartum hemorrhage from a projected rate of 18 percent to 1.7 percent in two hospitals. In Haiti, 100 percent of antenatal care (ANC) clients at Pignon Hospital received iron-folate supplements as measured over a 6-month period.

The White Ribbon Alliance is active in 24 countries, and over the past year the MNH Program supported the start-up of new alliances in China, Haiti, and Nigeria.

Additionally, the performance and quality improvement (PQI) program in Guatemala has resulted in two hospitals, four health centers, and four health posts receiving accreditation from the Ministry of Health as centers

of excellence for essential maternal and newborn care. Many more will receive accreditation this year. In Honduras, the Program is working in Region 5, where 25 percent of the country's population lives, to strengthen EMNC services using the PQI approach. In 2003, select hospitals achieved 59 percent of quality criteria—up from 20 percent in 2001. And in Burkina Faso, 76 percent of women attending ANC in select facilities received at least one dose of IPT, and 44 percent received two doses—up from zero only a year ago.

In West Java, Indonesia, births with a skilled provider increased from 43.2 percent in 1997 to 66.2 percent in 2003. And in the Koupéla district, in Burkina Faso, births with a skilled provider in 13 program sites increased from 36 percent in 2000 to 48 percent in 2003.

At the same time, the Program has developed and successfully implemented a variety of dynamic behavior change interventions using mass media and social mobilization, including community engagement. The White Ribbon Alliance is active in 24 countries, and over the past year the MNH Program supported the start-up of new alliances in China, Haiti, and Nigeria. In Indonesia, the Program's mobilization efforts within 55 *desa siaga* (alert villages) resulted in 221 hamlets establishing all four elements of the *desa siaga* system: notifying health providers of pregnant women, establishing savings schemes, establishing transport plans, and implementing blood donor systems. And in Guatemala, 78 percent of targeted communities have organized health committees and 26 percent of these have finalized community emergency plans. Community emergency plans have resulted in 52 referrals of obstetric complications to EMNC services in 2002 and 2003.

Perhaps most significant, the MNH Program's investments to date have contributed to an increase in childbirth with a skilled provider in both West Java, Indonesia, and in the Koupéla district in Burkina Faso. In West Java, births with a skilled provider increased from 43.2 percent in 1997 to 66.2 percent in 2003. And in the Koupéla district, births with a skilled provider in 13 program sites increased from 36 percent in 2000 to 48 percent in 2003.

These results and many others from 2002–2003 are discussed more fully in the following pages and are framed around the goals captured in the Program's legacy statements:

Establish and promote international evidence-based standards for essential maternal and newborn care through global partnerships

Improve the quality of skilled attendance by implementing international evidence-based standards and guidelines in national policy, curricula, and competency-based training

Generate shared responsibility and coordinated action among policymakers, health facilities, providers, communities, families, and women through birth preparedness and complication readiness

Scale up evidence-based practices, tools, and approaches through the adoption and adaptation of these practices by key organizations working in safe motherhood

Build the evidence base for social and behavior change interventions that generate informed demand and collective action for safe motherhood

Future

In the coming year, through implementation of its strategic approach, the MNH Program will continue to identify innovative solutions to the challenges in country programming and implementation. In addition, the Program will maintain and develop its partnerships with international donors, ministries of health and other local government bodies, and NGOs to ensure that global dialogue about safe motherhood is supported and that country needs for improved safe motherhood are met.

Continuing its close work with partners in every region, the Program will scale up its successful approaches, including curriculum development, training methods, demand generation strategies, and performance and quality improvement. The Program will pursue opportunities to disseminate lessons learned and to share tools and approaches with a broad range of collaborators to ensure the continuity of safe motherhood investments.

An important emphasis for 2004 is the measurement and documentation of the Program's results across all areas, especially the crucial progress made in policy, clinical services, and demand generation, as well as the impact of collaboration. Using population-based surveys, the Program will measure behavior change and the use of skilled providers at birth in four countries—Burkina Faso, Guatemala, Indonesia, and Nepal. The Program will also use facility-based data in countries such as Honduras, Tanzania, and Zambia to measure increased use of EMNC services. These and other quantitative data, as well as qualitative information related to programming, will be used to inform thinking about a full range of maternal and newborn health interventions and future directions in safe motherhood programming.

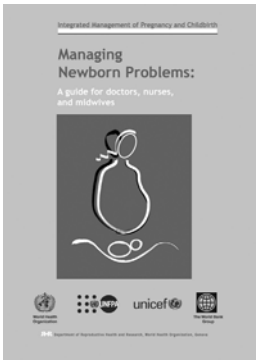
MNH Program Accomplishments and Results, 2002–2003

The accomplishments and results reported here are framed around the MNH Program legacy statements, which capture the Program's focus and goals in supporting the international safe motherhood agenda:

Legacy Statement 1: The MNH Program establishes and promotes international evidence-based standards for essential maternal and newborn care through global partnerships.

In order to improve the quality and availability of healthcare for mothers and newborns, the MNH Program and its partners have worked together since 1998 to establish and promote international evidence-based standards for care. These global standards are used to update and standardize practices at the regional and country level based on current international consensus about best practices in maternal and newborn healthcare. Through its partnerships, the MNH Program supports the development of consensus on standards of care and is able to broaden the implementation of these standards through supportive and complementary programming efforts. The MNH Program actively supports global partnerships, such as the Healthy Newborn Partnership, the International Research Partnership for Skilled Attendance for Everyone, and the Partnership for Safe Motherhood and Newborn Health, while working with country-level partners to achieve specific programmatic goals.

WHO and the Integrated Management of Pregnancy and Childbirth Series



Cover by World Health Organization

Perhaps most significant among the Program's global partnerships to promote international standards of care has been its ongoing collaboration with WHO on the publication of *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (*MCPC*) and *Managing Newborn Problems: A Guide for Doctors, Nurses, and Midwives*, two of the reference manuals in the WHO Integrated Management of Pregnancy and Childbirth (IMPAC) series. These two manuals and the others in the IMPAC series are setting the standard for the provision of essential maternal and newborn care globally.

Many countries have already integrated the standards from the *MCPC* manual into their national policy documents, curriculum development and revision, and training for maternal and newborn healthcare providers. The manual is now available in 11 languages, and WHO estimates that more than 1.5 million copies have been distributed. In October 2002, MNH

In Nepal, the MNH Program and its safe motherhood partners used the *MCPC* manual in the review of hospital protocols, the development of the Birth Preparedness Package, the creation of a job aid for maternal and child health workers, and the revision of the national curriculum for auxiliary nurse-midwives and maternal and child health workers.

Program staff attended the Latin American Federation of Societies of Obstetricians and Gynecologists (FLASOG) Conference in Santa Cruz, Bolivia, to launch and discuss information in the Spanish adaptation of the manual. Representatives from UNFPA, UNICEF, the Ministry of Health of Bolivia, and the Pan American Health Organization (PAHO) endorsed the manual at the conference. Since the launch of the Spanish adaptation, the Program has distributed more than 1,400 copies to program countries in Latin America. The manual and accompanying learning resource package are also distributed online through JHPIEGO's ReproLine® Website.

In collaboration with the West Africa Health Organization and UNICEF, the MNH Program supported the regional launch and dissemination in March 2003 of the French translation of the *MCPC* manual in West Africa. The French manual was also showcased and introduced in Haiti in May 2003 during the Maximizing Access and Quality Exchange meeting, which was attended by both policymakers and healthcare providers. UNFPA will provide resources to disseminate the *MCPC* manual and *Managing Newborn Problems* in Haiti.

The MNH Program and WHO completed work on *Managing Newborn Problems* in 2003. After 3 years of development, consultation, and collaboration worldwide, the international guidelines for the newborn manual were finalized and endorsed by UNFPA, the World Bank, the International Federation of Gynecology and Obstetrics (FIGO), and the International Confederation of Midwives. Publication by WHO is expected in 2004. As with the *MCPC* manual, the MNH Program is developing a comprehensive learning resource package to accompany the guidelines.

The development and dissemination of the IMPAC manuals have supported safe motherhood programming in MNH Program countries and beyond. For example, in **Indonesia**, all midwifery students, medical students, and ob/gyn residents now have access to Indonesia's adaptation of the *MCPC* manual, *Practical Guidelines for Maternal and Newborn Health.* At the September 2003 Indonesian Midwifery Association (IBI) National Congress, 94 percent of midwives who responded to a questionnaire reported that they have a copy of the *Practical Guidelines,* and the Program estimates that 100 percent of midwifery and medical students have access to the guidelines. In **Nepal**, the MNH Program and its safe motherhood partners used the *MCPC* manual in the review of hospital protocols, the development of the Birth Preparedness Package, the creation of a job aid for maternal and child health workers, and the revision of the national curriculum for auxiliary nurse-midwives and maternal and child health workers.

Additional Reference Manuals

The Program continued its work on the *Basic Maternal and Newborn Care* manual in 2003, drawing on expert review from Saving Newborn Lives and the American College of Nurse-Midwives. This manual is aligned with the IMPAC manuals, establishing a standard of care and guidelines for normal labor and childbirth. It is undergoing extensive external review by

WHO and other organizations, and is scheduled for publication in early 2004.

JHPIEGO's *Infection Prevention* manual was published in 2003, with support from the MNH Program in Indonesia, and was immediately used in Indonesia to assist the Government of Indonesia in preparing for a possible SARS epidemic. The manual and its learning resource package have been field-tested in Indonesia, Nepal, and Ukraine.

Partnering for the Prevention and Control of Malaria during Pregnancy

The MNH Program is an active participant in the Roll Back Malaria (RBM) partnership and is a lead partner in the USAID-funded Malaria Action Coalition (MAC), which includes WHO, CDC, and the Rational Pharmaceutical Management Plus (RPM-Plus) project. The MAC is designed to support the global malaria agenda and to provide technical assistance to African countries.

As part of its involvement in the RBM partnership, the Program provided input into the WHO/AFRO *Strategic Framework for Malaria Control during Pregnancy in the WHO Africa Region*. The strategic framework provides guidelines for policymakers and national programs for the prevention and case management of malaria in pregnant women, the main adult target group in the WHO Africa region. The strategic framework emphasizes intermittent preventive treatment (IPT) provided during antenatal care. Through partnership activities, the MNH Program has facilitated policy dialogue in countries such as Benin, Burkina Faso, and Zambia to support the implementation of this approach.

Cover by JHPIEGO

Using WHO/AFRO's Strategic Framework, the MNH Program developed the *Prevention and Control of Malaria during Pregnancy Reference Manual and Clinical Learning Materials Package* and has made it available to other organizations. This package will be used broadly in Africa as one important initiative in the Roll Back Malaria partnership. In addition, in collaboration with the MAC, the MNH Program has developed a new work plan for Ghana to support implementation of IPT, and a new work plan for Kenya to strengthen focused antenatal care services at the facility level and to strengthen preservice education to include prevention and control of malaria during pregnancy.

The Program also supports the RBM Working Group for Malaria during Pregnancy and facilitated the development and function of the Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition and the West African Network against Malaria during Pregnancy (RAOPAG). The MIPESA Coalition includes representatives from Kenya, Malawi, Tanzania, Uganda, and Zambia and receives technical support from WHO, CDC, USAID, and others. The RAOPAG Coalition includes

representatives from Benin, Burkina Faso, Côte d'Ivoire, Gambia, Guinea, Madagascar, Mali, Mauritania, Niger, Senegal, Sierra Leone, and Togo.

Both the MIPESA and RAOPAG coalitions are designed to facilitate inter- and intra-country policy dialogue and the exchange of lessons learned and best practices for the management of malaria during pregnancy. The MNH Program actively promotes the WHO Strategic Framework as well as evidence-based best practices through participation in these groups and implementation in select countries.

Building Consensus on Postpartum Hemorrhage Interventions

Because every woman is at risk for postpartum hemorrhage (PPH), skilled providers must know how to prevent this dangerous complication at every birth they attend. Above and beyond ensuring that providers have the knowledge and skills needed for care during labor and childbirth, efforts must be made to reach women who do not have access to skilled providers. These two goals—improving practices of skilled providers and developing ways of preventing PPH for those who do not have a skilled provider—formed the basis for MNH Program activities around PPH in 2002 and 2003.

The Program made significant progress toward those goals globally, regionally, nationally, and locally, focusing on the following:

- Participation in USAID's Special Initiative to Reduce Post-Partum Hemorrhage
- Participation in consensus-building with international professional associations and international organizations
- Research into a method to prevent PPH at the community level where there may not always be access to skilled providers
- Implementation of plans to ensure the correct and universal practice of active management of the third stage of labor in Zambia
- Continued inclusion of active management of the third stage of labor in all trainings for skilled providers as well as in standards/guidelines development activities

The MNH Program assisted USAID in organizing a groundbreaking meeting in Ottawa, Canada, in August 2003, which culminated in consensus on a Joint Statement on Prevention of PPH that both ICM and FIGO agreed to take to their members.

Prevention of Postpartum Hemorrhage Initiative

In September 2002, USAID requested assistance from its cooperating agencies to support national efforts to improve maternal health through its Special Initiative to Reduce Post-Partum Hemorrhage in Benin, Ethiopia, Mali, and Zambia. The MNH Program, the PRIME II project at IntraHealth, the Rational Pharmaceutical Management Plus (RPM Plus) project at Management Sciences for Health (MSH), and the American College of Nurse-Midwives (ACNM) were selected to implement the initiative. In addition, USAID coordinated with other international groups that influence the scope, practice, and technical guidance for preventing PPH such as WHO, UNICEF, FIGO, the Ob-Gyn Society of the West

African Region (SAGO), and the International Confederation of Midwives (ICM).

The importance of the MNH Program's participation in the PPH Initiative cannot be overstated. The Program assisted USAID in organizing a groundbreaking meeting in Ottawa, Canada, in August 2003. That ICM/FIGO Consensus Development Meeting followed an initial meeting (December 2002) in Washington, DC, where an attempt was made to produce a joint statement by ICM and FIGO on active management of the third stage of labor. The Ottawa meeting included representatives from both of those global professional associations, as well as the American College of Obstetricians and Gynecologists, ACNM, the Canadian Association of Midwives, the Canadian Society of Obstetricians and Gynecologists, WHO, the Population Council, the U.S. Pharmacopoeia, the Program for Appropriate Technology in Health (PATH), and USAID. The meeting culminated in consensus on a Joint Statement on Prevention of PPH that both associations agreed to take to their members.

Prevention of PPH in Zambia

The MNH Program in **Zambia** is supporting the national effort to make active management of the third stage of labor universal within the country. The Program has worked for several years to institutionalize evidence-based standards, including active management, through its work with the General Nursing Council to strengthen midwifery training and training facilities. Now, through the PPH Initiative, the Program is expanding its work to additional facilities and giving increased emphasis to improving providers' knowledge and skills in active management.

To implement its PPH Initiative program activities, the country used team meetings to gain consensus on the clinical protocols and guidelines to be used for program activities, and collected baseline data in four districts regarding current incidence and management of PPH. Three of the districts had already been recipients of MNH Program or other interventions that included knowledge and skills for active management. One of the districts had not had activities, and acted as the "control" for the study. The baseline assessment analysis by the evaluation team and Zambia's Central Board of Health representatives found many areas in need of improvement, despite knowledge and skill retention among those providers who were recipients of previous interventions. Most of those needs centered on systems issues that were barriers to the practice of active management of the third stage of labor (e.g., inadequate drug management systems and inadequate recordkeeping). As a result of the analysis, the four districts have begun implementing action plans that will address the barriers.

The Indonesia/SAFE study increased coverage of PPH prevention medications to 92 percent of all pregnant women in the study area and resulted in a 45 percent reduction in need for emergency referral for PPH.

Community Intervention for Prevention of PPH: SAFE Study

In July 2003, the MNH Program completed a collaborative study on the safety, acceptability, feasibility, and program effectiveness (SAFE) of community-based counseling and distribution of misoprostol, an orally administered drug, for the prevention of postpartum hemorrhage in

women in rural **Indonesia**. The Program collaborated with the Ministry of Health of Indonesia, the Indonesia Association of Obstetricians and Gynecologists (POGI), and WHO to conduct the study. The Indonesia/SAFE study increased coverage of PPH prevention medications to 92 percent of all pregnant women in the study area and resulted in a 45 percent reduction in need for emergency referral for PPH.

Legacy Statement 2: The MNH Program improves the quality of skilled attendance by implementing international evidence-based standards and guidelines in national policy, curricula, and competency-based training.

The MNH Program supports the implementation of international evidence-based standards and guidelines by advising and participating in the process of national policy development and providing technical assistance in the areas of training, site strengthening, performance and quality improvement (PQI), and curriculum development.

National Policy Development

In all countries, the MNH Program has worked at the national level with ministries of health, other government counterparts and institutions, and donor and NGO partners to set the stage for improved care through the revision of national policies, norms, and protocols (PNPs) for reproductive health and safe motherhood, and through the implementation of new policies and strategies that support safe motherhood services and healthcare providers. In 2003, the presentation of the results of the MNH Program SAFE study on community-based distribution of misoprostol in **Indonesia** led the Indonesia Ministry of Health to issue a resolution incorporating prevention of postpartum hemorrhage into the national health strategy, and to promote education and community-based distribution of misoprostol as an effective strategy for the reduction of PPH.

Photo by Marianne Elias

A newly trained midwife fills out a partograph at the Koupéla district hospital in Burkina Faso.

The MNH Program has also supported a number of ministries in developing and revising national policies and guidelines for maternal and newborn healthcare. In many cases, the *MCPC* manual has been used as the reference document in this process. For example, **MNH/Burkina Faso** contributed to the review and development of the national reproductive health PNPs by reviewing the section of the maternal health PNPs that covers essential and emergency obstetric care. In addition, MNH/Burkina Faso developed a pocket guide based on the PNPs and implemented the revised PNPs in its model system of essential and emergency obstetric care in the Koupéla district.

This valuable work has translated into an increase in the use of skilled providers at birth from 36 percent in 2000 to 48 percent in 2003 at 13 program sites.

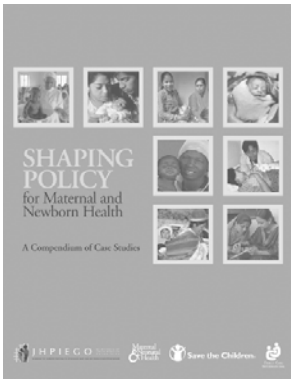
As a result of the Program's efforts, significant policy commitments have also been made toward institutionalizing EMNC services. **MNH/Zambia**, for example, continues to work with the Central Board of Health and the Reproductive Health Subcommittee to further the state of maternal and neonatal health policies and guidelines and to strengthen inservice training capacity in the country. MNH/Zambia played a key role in reviewing the safe motherhood section of the revised *Integrated Technical Guidelines for Front Line Health Workers*. Staff substantially updated and harmonized the guidelines with the *MCPC* manual.

MNH/Guatemala provided support for the inclusion of essential maternal and neonatal healthcare in the regular local initiatives of the National Reproductive Health Program. A total budget of $10 million, including all of the MNH Program interventions, was prepared for the National Reproductive Health Program and sent to the Ministry of Finance for approval. It will be sent to Congress for approval for the Guatemalan fiscal year that begins in January 2004. Also in Guatemala, the Vice Minister of Health has requested that the Guatemalan participants in the Latin America Midwifery Advocacy and Leadership Workshop, sponsored by the MNH Program, the POLICY II Project, and ICM, participate in a commission to revise the current laws and duties pertaining to graduated and auxiliary nurses.

The MNH Program in **Tanzania** worked with both the African Medical and Research Foundation and the Reproductive and Child Health Section of the Ministry of Health to develop guidelines on syphilis in pregnancy and the management of malaria during pregnancy under the umbrella of focused antenatal care. The *Focused Antenatal Care, Malaria and Syphilis in Pregnancy Orientation Package for Service Providers*, which is based on international standards of care and the *Strategic Framework for Malaria Control during Pregnancy in the WHO Africa Region,* is being used to strengthen antenatal care in Tanzania through the development of related clinical standards and provider orientation and training.

Using international standards and guidelines, the MNH Program and its collaborators are also facilitating the implementation of WHO/AFRO's policy for the prevention and control of malaria during pregnancy in Burkina Faso, Ghana, Kenya, Zambia, and other countries through participation in the MIPESA and RAOPAG coalitions. In August 2003, Ghana officially adopted IPT as its strategic approach. Data from interventions supported by the MNH Program and CDC in Burkina Faso's Koupéla district will be used to inform national policy change for malaria during pregnancy and the furtherance of this important work. Implementation of these new policies is expected to result in a 3–5 percent decrease in infant mortality rates in these countries and others.

Shaping Policy for Maternal and Newborn Health: A Compendium of Case Studies



Cover by JHPIEGO

The MNH Program's recent work with the policy process in several countries is documented in *Shaping Policy for Maternal and Newborn Health: A Compendium of Case Studies*, which the Program published, along with Saving Newborn Lives and Family Care International, in October 2003. The book represents a year-long collaborative effort to highlight how policy change occurs at the country level and how programs have contributed to securing national policy commitments for maternal and newborn health. It includes five case studies about the MNH Program's involvement in the policy development process:

- Using International Guidelines to Support National Policy in Maternal and Newborn Healthcare
- Using Advocacy to Promote Local Commitment to Maternal Health in Indonesia
- New Policies, Norms, and Protocols in Burkina Faso: An Important Step toward Improving Maternal and Newborn Healthcare
- CaliRed: A National Strategy for Improving Maternal and Newborn Healthcare in Guatemala
- Prevention and Control of Malaria during Pregnancy in Africa: From Research to Policy Change

Provider Training and Facility Improvements

As a result of the PQI initiative in Guatemala, in 2003 the Ministry of Health accredited two hospitals, four health centers, and four health posts as high-quality facilities for maternal and newborn healthcare.

The MNH Program's investment in enhancing provider competence and site strengthening has resulted in the increased use of evidence-based practices such as monitoring labor with the WHO standard partograph, limiting the routine use of episiotomy, consistently using active management of the third stage of labor, establishing skin-to-skin contact between mothers and their newborns, and immediate breastfeeding. The Program promotes the use of these practices through both its provider training approach and its training site development efforts. In addition, the Program's PQI approach, which enables facilities and communities to invest in ongoing quality monitoring and improvement, contributes to the institutionalization of these practices.

Results in country programs have been impressive. For example, MNH Program investment in site strengthening at two hospitals in West Java, **Indonesia**, has resulted in active management of the third stage of labor being practiced in 99.7 percent of births between 2001 and 2003. In **Haiti**, Hospital Justinien in Cap Haïtien now routinely uses the partograph, practices active management of the third stage of labor, restricts use of episiotomy, and practices immediate skin-to-skin contact. In addition, **Guatemala** and **Honduras**, two countries that have

implemented the Program's PQI approach, have made great strides in improving the quality of their maternal and newborn healthcare services. The PQI initiative in **Guatemala** resulted in two hospitals, four health centers, and four health posts receiving accreditation from the Ministry of Health in 2003 as high-quality facilities for maternal and newborn healthcare. In **Honduras**, the Program's implementation of PQI in six hospitals has brought about significant increases in the number of quality criteria met by the facilities. In Region 5, facilities increased their achievement of quality criteria in EMNC from 20 percent of criteria achieved in 2001 to 59 percent achieved in 2003. In Region 2, where the PQI process was implemented a year later, the percent of criteria achieved increased from 19 percent in 2002 to 36 percent of criteria in 2003.

The Program has also participated in policy changes to improve the standard of practice and training curricula for maternal and neonatal healthcare providers. In **Zambia**, active management of the third stage of labor has been or is being incorporated as a topic in the registered midwifery school curriculum, the enrolled midwifery curriculum, and the revised *Integrated Technical Guidelines for Front Line Health Workers*, and in all clinical training and revisions of standards and guidelines.

Regional Expert Development Initiative

A major initiative in the MNH Program's strategy to upgrade and support the skills of maternal and newborn healthcare providers came to fruition in 2003 with the completion of training and development for the Program's 47 regional experts. These experts have the skills to critically evaluate the evidence basis for changes in practices. They have been standardized and are proficient in key clinical skills and can transfer those skills to their workplace and to others. And they are advocates and agents for improving practices in their institutions, communities, and beyond. The regional experts are accelerating change to better practices in their own institutions and countries and within the region. A few highlights of the experts' accomplishments:

- Regional expert midwife Della Veraguaz has conducted a training skills course in Bolivia for PRIME.
- Blami Dao, a regional expert and ob/gyn from Burkina Faso, traveled to Haiti to assist in strengthening a proposed clinical training site in Cap Haïtien.
- Mohamed Bahar, a regional expert and doctor from Indonesia, led the clinical skills standardization for a national group of midwives, obstetricians, and anesthetist candidate trainers in Afghanistan.
- Regional expert Rajshree Ja from Nepal assisted the Ministry of Health in East Timor to design and implement a breastfeeding and baby-friendly movement for this new nation.
- Franz Conchari, an ob/gyn and regional expert from Bolivia, trained 37 providers and later trained four additional physicians to serve as trainers in EMNC. In January 2003, the Ministry of Health named Dr. Franz Conchari the official EMNC trainer at its *Unidad de Atención a las Personas*.

Preservice Education

The MNH Program supports the incorporation of skills development into preservice education as an investment in long-term improvements in the quality of skilled care. Preservice strengthening has been or is part of the MNH Program in most countries, including Afghanistan, Egypt, Guatemala, Honduras, Indonesia, Peru, and Zambia, and is supported by a global document, the *Preservice Implementation Guide: A Process for Strengthening Preservice Education*.

In 2003, a group of 21 midwives, who had started their education before the Taliban regime, completed their education and entered the workforce.

In **Zambia**, the MNH Program is supporting the implementation of the new enrolled midwifery curriculum. In **Indonesia**, the Program has completed revisions in curricular components for normal childbirth, newborn care, breastfeeding, and postpartum family planning, and has prepared the clinical training sites and developed the capacity of faculty at four large preservice midwifery schools to teach this curriculum. In **Egypt**, the MNH Program has completed an extensive assessment of four medical and midwifery schools as part of a large human workforce development program.

Photo by Ali Zazri, MNH/Indonesia

Midwifery students at Bandung Midwifery School in Bandung, Indonesia, complete a questionnaire about their new curriculum (May 2003).

In **Afghanistan,** where training of female healthcare workers was suspended under the Taliban (1996-2001), the MNH Program has been working with UNICEF, USAID, and the Aga Khan Development Network to increase the number of skilled providers, particularly midwives. In 2003, a group of 21 midwives, who had started their education before the Taliban regime, completed their education and entered the workforce. In addition, a class of 25 community midwives, a new cadre trained through an 18-month program, is nearing graduation under a HealthNet International program with the Program's technical assistance in curriculum development.

Finally, following technical assistance over the last 2 years, the MNH Program participated in the launch of the *Soins Obstetricaux et Neonatales d'Urgences* (SONU) curriculum at the preservice forum in Cotonu, Benin, in October 2002.

Emergency Obstetric Care Training

The MNH Program completed its competency-based training package for comprehensive emergency obstetric care (EmOC), including all the course

material required to train doctors, midwives, and anesthesia providers as well as tools to assess EmOC sites and evaluate the transfer of learning to the worksite. The materials have been extensively field-tested in a regional EmOC trainers' course in Southeast Asia through collaboration with AMDD and UNICEF. The trainers developed by the MNH Program have now conducted EmOC courses in their own countries of Afghanistan, Bangladesh, Bhutan, India, Nepal, and Pakistan. AMDD will provide the EmOC package to all 40 countries in its program. Followup assessment of the trainees demonstrated that they have the skills necessary to provide EmOC services effectively.

In response to this successful initiative, the Ministry of Health of Bangladesh has decided that the MNH Program-designed 17-week competency-based EmOC training, comprising classroom and onsite clinical training and mentoring, will replace the traditional year-long inservice apprenticeship. In Bhutan, all new doctors and midwives are now required to undergo the EmOC training in Thimpu before being posted to rural hospitals.

Using the BP/CR framework, country programs have made great strides in raising awareness of the concept of birth preparedness and complication readiness, in establishing shared responsibility for safe motherhood, and in promoting actions to ensure skilled care at birth, including the preparation of family and community emergency plans.

Legacy Statement 3: The MNH Program generates shared responsibility and coordinated action among policymakers, health facilities, providers, communities, families, and women through birth preparedness and complication readiness.

Birth preparedness/complication readiness (BP/CR) is both the central concept in the MNH Program's programmatic approach and the organizing framework for action to increase the use of skilled maternal and neonatal healthcare. Through BP/CR, the Program applies its technical expertise to improve service delivery, to generate awareness and demand for high-quality services, and to mobilize families, communities, and policymakers to take actions that will increase the use of skilled providers at birth. The Program works with each group of stakeholders—policymakers, health facilities, providers, communities, families, and women—to raise awareness of the importance of preparing for birth and potential complications and to encourage actions that will ensure that women seek, reach, and receive skilled care during pregnancy and childbirth and in the event of complications.

The responsibilities that each stakeholder group can take to ensure safe motherhood are outlined in the MNH Program's *Birth Preparedness/ Complication Readiness Matrix* (BP/CR Matrix), which is used as the framework for programming behavior change interventions, including social mobilization, in MNH Program countries (see **Appendix A**). Using the BP/CR framework, country programs have made great strides in raising awareness of the concept of birth preparedness and complication readiness, in establishing shared responsibility for safe motherhood, and in promoting actions to ensure skilled care at birth, including the preparation of family and community emergency plans.

In **Nepal**, where the national Safe Motherhood Subcommittee has helped to generate shared responsibility and coordinated action at the national level, the Safe Motherhood Network is included in the government's 15-year plan to increase BP/CR at the community level. The MNH Program's SUMATA (Care, Share, Prepare) mass media campaign encourages women to take appropriate actions—such as seeking antenatal care, saving money, and arranging transportation—to prepare for birth and possible complications. In 2003, MNH/Nepal launched the second phase of the campaign, which included the national daily broadcast of seven radio dramas disseminating safe motherhood messages; a series of six radio dramas with messages about essential obstetric care that targeted districts where such services are available; a series of street drama performances conducted in two districts (drawing an estimated 54,000 spectators for 92 performances); billboards erected at the Ministry of Health and Maternity Hospital in Kathmandu and in 17 districts (in collaboration with Nepal Family Health Program); and three episodes of a national broadcast television drama, *Ashaal Logne* ("good husband").

Photo submitted by MNH/Nepal

Nepal's Birth Preparedness Package is used in counseling a couple about birth preparedness and complication readiness.

In addition to the SUMATA campaign, Nepal has used its Birth Preparedness Package (BPP) to ignite community-level mobilization for birth planning in the two districts of Lalitpur and Baglung. Between January and May 2003, 3,379 individuals (938 pregnant women, 706 husbands, and 951 family members) received counseling with the BPP in Baglung. In Lalitpur, 933 pregnant women, 66 husbands, and 66 family members were counseled. In both districts, the number of women who reported making plans for birth (including arranging for a skilled provider, transport, and savings) increased after counseling, especially after several sessions. Preliminary results from the MNH Program's 2003 followup survey show that birth preparedness has improved since the baseline survey in 2001. For example, whereas only 1.5 percent of pregnant women reported arranging transport for childbirth in 2001, 13.7 percent reported arranging transport in 2003. In addition, 68.8 percent of women reported saving money for childbirth in 2003, up from 57.3 percent in 2001. The BPP has been fully endorsed by the government, which has recommended that it be implemented across the whole country.

In **Indonesia**, using the *desa siaga* (alert village) campaign, the MNH Program has supported the establishment of community emergency plans in 221 hamlets in the 55 intervention villages. The emergency plans cover the main BP/CR actions for which communities are responsible—notifying health providers when women are pregnant, establishing savings schemes, establishing transportations plans, and implementing blood donor systems. In addition, all 24 districts in West Java have adopted the BP/CR framework.

Community health committees and community emergency plans have also been developed in **Guatemala**. The Women's Presidential Secretariat has pledged to continue ministerial and intersectoral support for the village emergency plans, and buy-in and participation in the creation of the plans involves community members and the entire range of health facilities. Within the six MNH Program departments (El Quiché, Quetzaltenango, Retalhuleu, San Marcos, Sololá, and Suchitepéquez), 78 percent of targeted communities have organized a health committee, 35 percent have organized an emergency fund scheme, 43 percent have identified transportation for an emergency, and 26 percent have finalized a community emergency plan. Community emergency plans resulted in 52 referrals of obstetric complications to EMNC services in 2002 and 2003.

The MNH Program in **Burkina Faso** has established a process for communication among providers, village health management committees, communities, the district health management team, and partners in order to improve collaboration and sharing of responsibility. Through this effort, which uses performance and quality improvement tools, the community now has a system of cost sharing for the care of obstetric and surgical emergencies and a system of rapid communication between health facilities. Thanks to the cost-sharing system, 58 women in Koupéla benefited from a 60 percent reduction in their out-of-pocket costs for emergency obstetric care in 2003.

In **Bolivia**, to address the lack of adequate transport for pregnant women, the MNH Program established an emergency medical system (SUMA 911) in the city of El Alto. The decentralized system organizes transportation and communication networks for all types of health emergencies. It is funded by the national health insurance (Seguro Básico) and by clients, so it is self-sustaining. Since it was established in 2002, SUMA 911 has provided a critical referral system for women with obstetric emergencies.

Photo by Angela Nash-Mercado

More than 400 people from 35 nations gathered for the first global White Ribbon Alliance conference in India, where the WRA's Ribbon of Life Quilt was unveiled.

The BP/CR concepts and the BP/CR Matrix play an important role in the MNH Program's social mobilization activities, which are designed to encourage dialogue and build partnerships among the BP/CR stakeholder groups, ultimately leading to changes in policies related to safe motherhood. Chief among these is the Program's leadership and support of the White Ribbon Alliance (WRA). The MNH Program serves on the WRA's Decision-Making and International Committees, and the Alliance has now expanded to 24 countries and more than 200 individual and organizational members. The Program has been an active contributor to and organizer of the WRA's global and regional conferences, including the first global conference held in New Delhi, India, in October 2002.

In 2003, the MNH Program collaborated with NGO Networks for Health on the publication of a history of the WRA, *Building a Global Movement: The White Ribbon Alliance for Safe Motherhood, 1999-2003*. In addition, the Program provided technical assistance to several new and growing country alliances. For example, the MNH Program assisted in the start-up of new alliances in China, Haiti, and Nigeria. With the Program's support, the new alliance in Burkina Faso scaled up and began to form a national secretariat. The White Ribbon Alliance in Indonesia (Pita Putih) has developed models for community-based birth preparedness through the SIAGA campaign, has successfully increased funds for safe motherhood at the district level, and has obtained endorsement from three ministries.

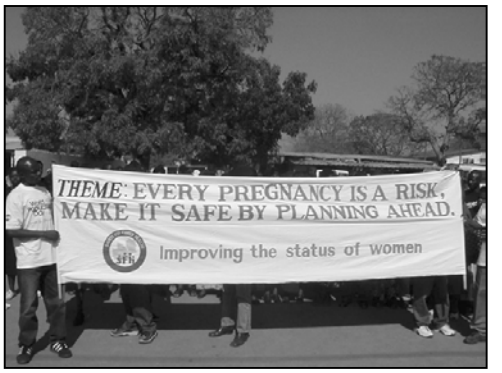


Photo by Rick Hughes

The banner for a World Population Day march in Zambia shows one of the key birth preparedness themes adopted as a slogan by the Zambia White Ribbon Alliance for Safe Motherhood.

The MNH Program supported the use of the BP/CR Matrix in China, Haiti, India, and Nigeria as a tool to build partnerships and plan focused action. The initiation of the local WRA in **China**, for example, generated considerable interest in the BP/CR Matrix, which was then translated into Chinese and used as a mapping tool for planners at the district level. Similarly, in **Nigeria**, at the request of the USAID mission, the local alliance used the BP/CR Matrix to plan activities related to prevention of mother-to-child transmission of HIV/AIDS. Likewise, the BP/CR Matrix was used during the introduction of the WRA in **Haiti** and has since been translated into Creole. Key birth preparedness themes—such as "Every pregnancy is a risk. Make it safe. Plan ahead."—have been adopted as slogans by the WRA in **Zambia** as well, and the BP/CR Matrix and concepts have been incorporated into activities such as a safe motherhood capacity-building workshop, a national neighborhood health committee distance learning radio program and job aids, and a journalists' competition.

Legacy Statement 4: The MNH Program scales up evidence-based practices, tools, and approaches through the adoption and adaptation of these practices by key organizations working in safe motherhood.

Scale-up is crucial to ensuring broad-based programming, the achievement of program results, and the institutionalization of tools and approaches. The MNH Program's products, tools, and approaches are being implemented and scaled up through its country programs, through

regional coalitions and partnerships, and through its work with other international organizations involved in safe motherhood.

In 2002–2003, through participation in global, regional, and country-level partnerships, the MNH Program facilitated the wide dissemination of global guidelines, best practices, and effective approaches within and beyond MNH Program countries. The Program sponsored or contributed to the maternal and newborn survival agenda at numerous global and regional meetings and responded to special requests for training activities. For example:

- The MNH Program gave keynote addresses and other presentations at regional meetings of the Asia Oceanea Federation of Obstetrics and Gynaecology (AOFOG), the East Central and Southern Africa Association of Obstetrics and Gynecology (ECSAOGS), and the Federation of Latin American Societies of Obstetrics and Gynecology (FLASOG) to promote the use of evidence-based best practices and mobilize professional associations to support public health approaches.

To date, the MNH Program has contributed to training 80 midwives, representing 24 countries in Africa, Asia, and Latin America, in maternal health policy and advocacy. These midwives have gone on to initiate advocacy and policy activities with their national midwifery associations.

- The MNH Program hosted the West African regional workshop on "Best Practices in Maternal and Neonatal Health" in Burkina Faso. A total of 84 participants from 11 countries in francophone Africa had the opportunity to hear about evidence-based practices, visit model sites, and participate in the White Ribbon Alliance social mobilization activities in Koupéla and the launch of the French version of the *MCPC* manual.
- Given the promising results of the SAFE study in **Indonesia**, the Ministry of Health of Indonesia intends to scale up education and community-based distribution of misoprostol as an effective strategy for the reduction of PPH. The MNH Program presented results of the study to the National Steering Committee in Indonesia in June 2003, to USAID in July 2003, to POGI in July 2003, and at the Indonesian Midwifery Association meeting in September 2003. The Program secured funding to conduct a regional meeting in 2004 in the Asia/Near East region of USAID to provide evidence on methods of preventing postpartum hemorrhage, including community use of misoprostol, and to discuss ways to scale up in the region.
- In December 2002, MNH/Indonesia staff participated in a WHO/SEARO meeting in New Delhi where implementation of the *MCPC* manual and *Pregnancy, Childbirth, Postpartum and Newborn Care* (another manual in the IMPAC series) was discussed. Representatives of 10 SEARO countries attended the meeting and acknowledged the MNH Program for its role in developing the learning resource package and implementing competency-based training materials based on the *MCPC* manual.
- Along with the POLICY II Project and the International Confederation of Midwives (ICM), the MNH Program sponsored the final of three regional Midwifery Leadership and Advocacy Workshops in Lima, Peru, from 10 to 15 February 2003. Twenty-

eight midwives from Argentina, Bolivia, Ecuador, Guatemala, Mexico, Paraguay, Peru, and Uruguay developed and strengthened their skills as midwifery advocates. To date, 80 midwives representing 24 countries in Africa, Asia, and Latin America have been trained in maternal health policy and advocacy.

These midwives have gone on to initiate advocacy and policy activities with their national midwifery associations. For example, midwives in Zimbabwe convinced the Ministry of Health of Zimbabwe to change its response to a religious group whose members do not believe in hospital care for their children, pregnant women, or sick adults. Based on what they learned in the leadership and advocacy workshops, the midwives approached the Ministry about alternatives to prosecuting the families. They are now running workshops for the religious group in their churches with the support of the church leaders, and are also discussing collaboration with local obstetricians and pediatricians, which would provide a combined front for reducing maternal and neonatal mortality and morbidity in this segment of the population. As a result of their leadership and advocacy training, midwives in the South Africa national association have worked with the Ministry of Health and Ministry of Social Affairs to tackle violence against young girls and women. The association has been able to influence policy on the management of sexual assault, has been running campaigns to reduce sexual assault (with the full support of the government and related ministries), and is hoping to influence the revision of existing laws on sexual assault to make them more protective of young girls and women.

Collaboration has been integral to scale-up at every level, creating a broader avenue for dissemination, additional resources leveraged toward MNH Program goals, and a foundation for sustainable programming.

The MNH Program has worked with national ministries and national and regional stakeholders to support the implementation of the WHO policy for the management of malaria during pregnancy. For example, the Program provided technical guidance in Kenya and Uganda to pilot the Roll Back Malaria global indicators for malaria during pregnancy and test the feasibility of their use at the facility level. The results of the pilot will influence the monitoring of health services throughout Africa, because the indicators are designed to be adapted to existing systems. In **Tanzania**, the Program collaborated with the Ministry of Health to develop and finalize the national antenatal care guidelines and the focused antenatal care orientation package used for inservice training for delivering IPT during pregnancy. According to the Tanzania National Malaria Control Program, IPT coverage in Tanzania increased from 29 percent in 2001 to 65 percent in 2003, and the increase is attributable in part to the development of the guidelines and orientation package. In **Zambia**, the Program worked with the national malaria control program and the national reproductive health program to develop an orientation package for the management of malaria during pregnancy in focused antenatal care. The MNH Program continues to work with the Ministry of Health in Zambia to train trainers and providers in the use of IPT with sulfadoxine-pyrimethamine through focused antenatal care services.

Country-Level Impact

The Program's practices, tools, and approaches have been widely disseminated through professional meetings, training, curriculum development, and partnerships in both MNH Program and non-Program countries. Collaboration has been integral to scale-up at every level, creating a broader avenue for dissemination, additional resources leveraged toward Program goals, and a foundation for sustainable programming.

In **Burkina Faso**, where the MNH Program works closely with UNICEF, UNFPA, and Plan International, Program activities and results have been expanded through the commitment of partner resources. UNICEF funded the installation of a rapid communication system between health centers and Koupéla Hospital, the training of village health management committees in performance improvement throughout the Koupéla district, the training of pharmacy managers in performance improvement, support for the Diapaga district health management team in the application of MNH Program approaches, the training of regional providers in focused antenatal care and malaria during pregnancy, and reproduction of MNH/Burkina Faso's social mobilization flipchart. Collaboration with the UNICEF Regional Office for West and Central Africa enabled 27 providers and program managers from eight countries (Benin, Central African Republic, Côte d'Ivoire, Democratic Republic of Congo, Guinea, Mali, Niger, and Senegal) to receive training in focused antenatal care and malaria during pregnancy. The Program is assisting UNICEF with additional training in malaria during pregnancy for the Democratic Republic of Congo, Gabon, and Ghana. UNFPA has contributed to provider training in use of the partograph, regional training in focused antenatal care and malaria during pregnancy, and reproduction of the social mobilization flipchart. Plan International funded provider training in infection prevention and complementary equipment. In addition, through financing from Save the Children and technical assistance from MNH Program expert trainers, providers in Mali and Guinea have adopted MNH Program clinical approaches.

In Guatemala, PAHO, UNFPA, CARE, and Project HOPE have adopted the MNH Program's PQI methods, which has led to the expansion of PQI into 222 additional health facilities.

In **Guatemala**, PAHO, UNFPA, CARE, and Project HOPE have adopted the MNH Program's PQI methods, which has led to the expansion of PQI into 222 additional health facilities. The Program leveraged more than $620,000—from government sources, international cooperating agencies, NGOs, and the private sector—toward the financing of interventions in the PQI initiative in the first 8 months of 2003 alone. In 2003, presentations on the approach were given at the World Bank, the Asia and Pacific Conference in Bangkok, and the International Society for Quality in Health Care (ISQua) meeting.

In addition, MNH/Guatemala facilitated the distribution of 7,500 copies of its *Guidelines for Preparing an Emergency Plan* to nearly 2,000 community facilitators working in 6,332 communities—reaching approximately 30 percent of the country's communities. UNFPA will fund the printing of another 6,000 copies and distribution in an additional four health districts. MNH/Guatemala and JHU/CCP developed a manual, *Interpersonal and Intercultural Communications*, for use in a 1-year distance education program

in health communications for 150 professionals, which MNH/Guatemala is conducting with the Guatemala Nutritionists Association.

In a cross-border PQI initiative, the Vice-Minister of Health and the Director of the MNH Program in **Guatemala** participated in a stakeholders' meeting in **Honduras** that was attended by the Honduran Vice-Minister of Health/central level, regional and hospital directors, and representatives from cooperating agencies. This meeting provided a platform to formally present the results of work in Honduras Health Regions 2 and 5 to the MOH, begin discussions on the institutionalization of the PQI process, and exchange experiences between Honduras and Guatemala. The Guatemalan and Honduran representatives discussed the possibilities of conducting regular cross-country visits, making inter-ministerial declarations, planning regional conferences, conducting inter-country training for medical and nursing students, preparing a bi-national newsletter, and establishing a bi-national accreditation process.

Since the MNH Program began in Haiti in 2002, MNH/Haiti has expanded from three to five sites, and it is currently adding 10 additional sites to secure national coverage.

Collaboration is the cornerstone of the MNH Program in **Haiti** and has already widened the Program's impact. Examples include work in preservice education with the school of midwifery; partnering with the Haiti Hospital Foundation and Hospital Albert Schweitzer; providing technical assistance to the Ministry of Health to develop the national safe motherhood strategy and framework; and leading the development of national indicators for antenatal care. Since the Program began in Haiti in 2002, MNH/Haiti has expanded from three to five sites, and it is currently adding 10 additional sites to secure national coverage.

In **Afghanistan**, the MNH Program's work with multiple partners, including USAID, UNICEF, the Aga Khan Development Network, HealthNet International, AMDD, and Management Sciences for Health, has broadened the Program's scope and impact from its initial targeted support of two midwifery schools to a larger program involving the development of clinical standards and guidelines; support to the Institute for Health Sciences (IHS) to standardize midwifery education nationally and develop expertise in training approaches and systems; development and monitoring of grants to NGOs to develop and deliver midwifery education; technical assistance in clinical service delivery, training approaches, and use of performance and quality improvements tools; strengthening referral hospital capacity in emergency obstetric care; technical assistance in maternal and neonatal healthcare to NGOs delivering the Basic Package of Health Services to Afghan communities; and advising staff working on community-based and management initiatives to ensure coordination and linkages.

MNH/Honduras received $40,000 from the Ministry of Health to provide four training courses: one in instructional design for six preservice faculty and three in EMNC clinical skills for 38 providers from hospitals, maternity clinics, and health centers in Regions 2 and 5. In addition, the Quality Assurance Project covered participant and logistical costs for basic EMNC training for auxiliary nurses in Siguatepeque. The adaptation of the EMNC learning package from a 2-week course to a 7-day course

for auxiliary nurses shows commitment to improving skills across professions and to a methodology that has been proven effective.

MNH/Indonesia held a national presentation of the *desa siaga* model at a UNICEF-sponsored workshop in March 2003. As a result, two UNICEF officers are planning to visit Kuningan to determine the feasibility of replicating the model as part of the new national information, education, and communication strategy. Approximately 17 percent of non-Program districts in Indonesia are already replicating MNH Program tools and approaches. In addition, in collaboration with a wide group of national and international stakeholders, the MNH Program supported the development of a national newborn strategy for Indonesia.

In **Nepal**, the MNH Program enjoys a high degree of collaboration with partners and has been able to scale up a number of products. The USAID-funded Nepal Family Health Program, GTZ, and the United Mission to Nepal have distributed SUMATA posters and other behavior change materials to an array of districts. Resources leveraged from partners include UNFPA funding through the Safe Motherhood Partnership Program; Nepal Safer Motherhood Project funding for the printing of SUMATA banners, lampshades, posters, and Birth Preparedness Package materials; and Saving Newborn Lives' implementation and monitoring of the Birth Preparedness Package in the Siraha district.

MNH/Zambia disseminated Zambia's revised technical guidelines for treatment and care of malaria, which include the policy of IPT with SP, to all nine provinces and 72 districts, orienting more than 450 health managers and providers and involving government, WHO, UNICEF, and other partners. In addition, the guidelines have been incorporated into national scale-up materials for preventing mother-to-child transmission of HIV/AIDS. The MNH Program's BP/CR concepts (such as birth preparedness, danger signs in pregnancy, and birth planning) have been incorporated into national neighborhood health committee distance learning radio programs and job aids. UNFPA selected the Zambia White Ribbon Alliance for Safe Motherhood as a key implementing partner for its new country program.

In Burkina Faso, the MNH Program's support for a participatory community self-evaluation process has encouraged women to use high-quality health services. The participatory process may be one contributor to an overall increase in the number of first-time users of antenatal care in the Koupéla district. The number of first-time users of antenatal care rose from 66 percent of pregnant women targeted in the district in 2000 to 85 percent in 2003.

Legacy Statement 5: The MNH Program builds the evidence base for social and behavior change interventions that generate informed demand and collective action for safe motherhood.

The MNH Program's innovative programming approach, integrating behavior change and social mobilization with the promotion of evidence-based clinical interventions, has distinguished the Program in the field and led to its achievements in working with communities to demand high-quality healthcare services for mothers and newborns. The Program developed the concepts of "informed demand" and "collective action" in this context, defining them as the engines for improving birth preparedness, and has designed strategies to promote demand and action for birth preparedness and complication readiness.

The Program's groundbreaking work with the White Ribbon Alliance and implementation of the BP/CR concept and tools have encouraged community involvement in safe motherhood as well as regional, national, and global action to reduce maternal and newborn mortality. In **Indonesia,** the Program has established the *desa siaga* (alert village) system and is working in 55 villages to build community awareness and responsiveness to the BP/CR concept. And in **Burkina Faso**, the Program's support for a participatory community self-evaluation process has encouraged women to use high-quality health services. The participatory process may be one contributor to an overall increase in first-time use of antenatal care in the Koupéla district. The number of first-time users of antenatal care rose from 66 percent of pregnant women targeted in the district in 2000 to 85 percent in 2003.

The MNH Program is contributing to the body of evidence about demand generation for maternal and neonatal healthcare services. The Program's SAFE study in **Indonesia**, for example, relied on trained community volunteers to distribute misoprostol tablets to pregnant women during the late antenatal period, and to provide counseling and education on correct timing of the use of misoprostol tablets immediately after the birth. The study is generating new learning on the acceptability of the intervention, safety in communities, and program effectiveness—with implications not only for the prevention of postpartum hemorrhage, but also for using a community-based program to raise awareness and increase demand for the intervention.

The Program has also examined the role that cultural factors play in women's pursuit of care for postpartum hemorrhage in a paper titled "Perceptions Matter: Women's Health Care Seeking Behavior in the Event of Post-Partum Hemorrhage," which has been accepted by the *Journal of Midwifery and Women's Health*. Finally, *Demand Generation in Safe Motherhood*, a case study on the role of demand generation in **Honduras**, where the maternal mortality rate has decreased, will contribute to the literature on the role of demand generation and behavior change in the reduction of maternal mortality.

In 2003, the MNH Program began focusing on collecting and documenting its social mobilization and behavior change approaches, tools, and results of its work, in an effort to contribute to further programmatic advances in these areas. Among the documentation projects completed in 2003 are the following:

- The MNH Program and NGO Networks for Health documented the development of the WRA in a brief history, *Building a Global Movement: The White Ribbon Alliance for Safe Motherhood, 1999-2003*. The report was published in May 2003.
- With CEDPA's ENABLE Project, the Program published *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood*, which documents social mobilization approaches and achievements. Examples and lessons learned from the MNH Program and the ENABLE Project focus on experiences in Burkina

Faso, India, Indonesia, Nepal, Nigeria, and Zambia. The report was published in October 2003.

In the coming year, the MNH Program will continue to build the evidence base for social and behavior change interventions through the following projects:

- The *Igniting Change for Safe Motherhood Toolkit* is being developed to help groups involved in planning and implementing social mobilization strategies to understand and capture the impact of their efforts while building their capacity to function as coalitions. The tools will help to document country experiences and will serve as a resource for strengthening safe motherhood coalitions. They have already been used with the WRA of India to help the alliance identify priority areas for work with each stakeholder level.
- The BP/CR Index and Toolkit, a joint project of JHPIEGO and JHU/CCP staff, includes a focused list of indicators to measure birth preparedness and complication readiness across all six levels of actors described in the BP/CR Matrix. The toolkit will allow countries to assess their own progress in promoting BP/CR at every level.
- The Program is preparing three case studies that will capture the role of communication strategies in fueling informed demand for safe motherhood in Bolivia, Nepal, and Zambia. The case studies highlight effective and appropriate communications strategies to increase informed demand, descriptions of innovative initiatives, and a discussion of lessons learned. The uniqueness of each MNH Program country strategy is conveyed in descriptions of materials and stories and anecdotes from the field.

Conclusion

In 5 years, the MNH Program has expanded the reach and effectiveness of the safe motherhood movement, providing both technical and programmatic leadership to the development and promotion of international evidence-based standards of care and policies to support them, to improvements in the quality of skilled attendance (through curriculum development, competency-based training, and PQI), and to generating demand for high-quality care through BP/CR. Through collaboration at the national, regional, and global levels, the MNH Program and its partners have further promoted the use of the Program's tools and approaches as well as the evidence-based practices it supports.

Photo submitted by MNH/Nepal

The MNH Program display at International Women's Day (Nepal Safe Motherhood Day), Patan Durbar Square, Kathmandu, Nepal.

At the country level, the MNH Program enjoys strong support from national ministries, local governments, and international and national partners due to its responsiveness, flexibility, and record of high-quality technical assistance, as well as its demonstrated collaboration with a wide variety of donors and stakeholders. Across its program countries, the MNH Program has improved the quality of services, increased political support for safe motherhood, empowered and informed communities, and increased use of essential maternal and newborn care services, including care from a skilled provider at birth.

The MNH Program is proud to report these significant achievements in increasing the use of essential maternal and newborn healthcare services. We also recognize that there are many challenges ahead for all of us working in safe motherhood. We look forward to further analysis of results both past and still being generated and to sharing further the lessons learned through our rich experiences in all of these areas in the coming year and beyond.

Appendix A

Birth Preparedness and Complication Readiness: A Matrix of Shared Responsibility

The MNH Program's Birth Preparedness/Complication Readiness Matrix outlines the key actions that women, families, communities, providers, facilities, and policymakers can take to ensure safe motherhood. The matrix is used as the framework for programming behavior change interventions, including communication strategies and social mobilization—to raise awareness and bring stakeholders together to share in the responsibility for saving the lives of women and newborns. Actions stakeholders can take are listed in sections covering pregnancy, labor and childbirth, and the postpartum/newborn period. A reprinted version of the matrix appears on the following pages.

For a copy of the printed matrix in poster size, contact Angela Nash-Mercado at anashmercado@jhpiego.net. It is also available in PDF format on the MNH Program Website: www.mnh.jhpiego.org. The matrix is available in English, French, and Spanish.

PREGNANCY

POLICYMAKER	FACILITY	PROVIDER
Creates an environment that supports the survival of pregnant women and newborns.	*Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.*	*Provides skilled care for normal and complicated pregnancies, births and the postpartum period.*
Promotes health and survival for pregnant women and newborns Ensures that skilled antenatal care policies are evidence-based, in place and politically endorsed Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines Promotes and facilitates the adoption of evidence-based antenatal care Ensures that adequate levels of resources (financial, material, human) are dedicated to supporting antenatal care and an emergency referral system Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals and advocacy groups Coordinates donor support to integrate birth preparedness and complication readiness into antenatal services Has a national policy document that includes specific objectives for reducing maternal and newborn deaths Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)	Has essential drugs and equipment Follows infection prevention principles and practices Has a functional emergency system, including: • communication • transportation • safe blood supply • emergency funds Has service delivery guidelines on appropriate management during the antenatal period Has job aids to assist providers in performing appropriate antenatal care Ensures availability of a skilled provider 24 hours a day, 7 days a week Is gender and culturally sensitive, client-centered and friendly Involves community in quality of care Reviews case management of maternal and neonatal morbidity and mortality	Provides skilled antenatal care, including: • detecting and managing complications • **promoting health and preventing disease, including:** – provision of iron/folate and tetanus toxoid – vitamin A and iodine in areas with deficiencies – presumptive treatment of malaria and worms in areas of prevalence – encourages use of bed nets • screening for and managing HIV/AIDS, tuberculosis, STDs • assisting the woman to prepare for birth including: – items needed for clean birth – identification of skilled provider for the birth – plan for reaching provider at time of delivery – identification of support people to help with transportation, care of children/household, and accompaniment to health facility – Complication Readiness Plan in case of emergency: emergency funds, transportation, blood donors, and decision-making • counseling/educating the woman and family on danger signs, nutrition, family planning, breastfeeding, HIV/AIDS • informing woman and family of existence of emergency funds • referring to higher levels of care when appropriate • honoring the pregnant woman's choices Supports the community s/he serves Respects community's expectations and works within that setting Educates community members about birth preparedness and complication readiness Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness

COMMUNITY	FAMILY	WOMAN
Advocates and facilitates preparedness and readiness actions.	*Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.*	*Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.*
Supports and values the use of antenatal care Supports special treatment for women during pregnancy Recognizes danger signs and supports implementing the Complication Readiness Plan Supports mother- and baby-friendly decision-making for normal births and obstetric emergencies Has a functional transportation infrastructure for woman to reach care when needed Has a functional blood donor system Has community financing plan for obstetric emergencies Can access facility and community emergency funds Conducts dialogue with providers to ensure quality of care Dialogues and works together with provider on expectations Supports the facility that serves the community Educates members of the community about birth preparedness and complication readiness Advocates for policies that support skilled healthcare Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness	Advocates for skilled healthcare for woman Supports and values the woman's use of antenatal care, adjusts responsibilities to allow attendance Makes plan with woman for normal birth and complications Identifies a skilled provider for childbirth and the means to contact or reach the provider Recognizes danger signs and facilitates implementing the Complication Readiness Plan Identifies decision-making process in case of obstetric emergency Knows transportation systems, where to go in case of emergency, and support persons to accompany and stay with family Supports provider and woman in reaching referral site, if needed Knows supplies to bring to facility or have in the home Knows how to access community and facility emergency funds Has personal savings for costs associated with emergency care or normal birth Knows how and when to access community blood donor system Identifies blood donor	Attends at least four antenatal visits (obtains money, transport) Makes a birth plan with provider, husband, family Decides and acts on where she wants to give birth with a skilled provider Identifies a skilled provider for birth and knows how to contact or reach the provider Recognizes danger signs and implements the Complication Readiness Plan Knows transportation systems, where to go in case of emergency, and support persons to accompany and stay with family Speaks out and acts on behalf of her and her child's health, safety and survival Knows that community and facility emergency funds are available Has personal savings and can access in case of need Knows who the blood donor is

LABOR AND CHILDBIRTH

POLICYMAKER	FACILITY	PROVIDER
Creates an environment that supports the survival of pregnant women and newborns.	*Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.*	*Provides skilled care for normal and complicated pregnancies, births and the postpartum period.*
Promotes improved care during labor and childbirth Ensures that skilled care policies for labor and childbirth are evidence-based, in place and politically endorsed Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines Promotes and facilitates the adoption of evidence-based practices Supports policies for management of complications based on appropriate epidemiological, financial and sociocultural data Ensures that adequate levels of resources (financial, material, human) are dedicated to skilled care at birth and an effective emergency referral system Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals, and advocacy groups Coordinates donor support for improved management of labor and childbirth Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)	Has essential drugs and equipment Follows infection prevention principles and practices Has appropriate space for birthing Has a functional emergency system, including: • communication • transportation • safe blood supply • emergency funds Has service delivery guidelines on appropriate management of labor and childbirth Has job aids to assist providers in performing labor and childbirth procedures Ensures availability of a skilled provider 24 hours a day, 7 days a week Is gender and culturally sensitive, client-centered and friendly Involves community in quality of care Reviews case management of maternal and neonatal morbidity and mortality	Provides skilled care during labor and childbirth, including: • assessing and monitoring women during labor using the partograph • providing emotional and physical support through labor and childbirth • conducting a clean and safe delivery including active management of 3rd stage of labor • recognizing complications and providing appropriate management • informing woman and family of existence of emergency funds (if available) • referring to higher levels of care when appropriate Supports the community s/he serves Respects community's expectations and works within that setting Educates community about birth preparedness and complication readiness Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness

COMMUNITY	FAMILY	WOMAN
Advocates and facilitates preparedness and readiness actions.	*Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.*	*Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.*
Supports and values use of skilled provider at childbirth Supports implementing the woman's Birth Preparedness Plan Makes sure that the woman is not alone during labor, childbirth and immediate postpartum period Supports the woman in reaching place and provider of her choice Has a functional blood donor system Recognizes danger signs and supports implementing the Complication Readiness Plan Supports mother- and baby-friendly decision-making in case of obstetric emergencies Can access facility and community emergency funds Supports timely transportation of woman Promotes community norms that emphasize priority of transportation for pregnant women and obstetric emergencies Dialogues and works together with provider on expectations Supports the facility that serves the community Advocates for policies that support skilled healthcare Promotes concept of birth preparedness and dispels misconceptions and harmful practices that could prevent birth preparedness and complication readiness	Advocates for skilled healthcare for woman Recognizes normal labor and facilitates implementing Birth Preparedness Plan Supports woman in reaching place and provider of choice Supports provider and woman in reaching referral site, if needed Agrees with woman on decision-making process in case of obstetric emergency Recognizes danger signs and facilitates implementing the Complication Readiness Plan Discusses with and supports woman's labor and birthing decisions Knows transportation systems, where to go in case of emergency, and support persons to stay with family Knows how to access community and facility emergency funds Has personal savings for costs associated with emergency care or normal birth Purchases necessary drugs or supplies Knows how and when to access community blood donor system Identifies blood donor	Chooses provider and place of birth in antenatal period Recognizes normal labor and understands Birth Preparedness Plan Recognizes danger signs and understands Complication Readiness Plan Knows transportation systems, where to go in case of emergency, and support persons to stay with family Can access community and facility emergency funds Has personal savings and can access in case of need

POSTPARTUM AND NEWBORN

POLICYMAKER	FACILITY	PROVIDER
Creates an environment that supports the survival of pregnant women and newborns.	*Is equipped, staffed and managed to provide skilled care for the pregnant woman and newborn.*	*Provides skilled care for normal and complicated pregnancies, births and the postpartum period.*
Promotes improved postpartum and newborn care Ensures that skilled postpartum and newborn care policies are evidence-based, in place and politically endorsed Uses evidence-based information to support systems that routinely update service delivery and cadre-specific guidelines Promotes and facilitates the adoption of evidence-based practices Supports policies for management of postpartum and newborn complications using appropriate epidemiological, financial, and sociocultural data Ensures adequate levels of resources (financial, material, human) are dedicated to supporting the skilled management of postpartum and newborn care and the effectiveness of an emergency referral system Encourages and facilitates participation in policy-making and resource allocation for safe childbirth and emergency referral services by communities, families, individuals and advocacy groups Coordinates donor support for improved postpartum and newborn care Ensures that protocols are in place for clinical management, blood donation, anesthesia, surgical interventions, infection prevention and physical infrastructure Advocates birth preparedness and complication readiness through all possible venues (e.g., national campaigns, press conferences, community talks, local coalitions, supportive facilities)	Has essential drugs and equipment Follows infection prevention principles and practices Has a functional emergency system, including: • communication • transportation • safe blood supply • emergency funds Has service delivery guidelines on care of newborn and mother postpartum Has job aids to assist providers in performing appropriate postpartum and newborn care Ensures availability of a skilled provider 24 hours a day, 7 days a week Is gender and culturally sensitive, client-centered and friendly Involves community in quality of care Reviews case management of maternal and neonatal morbidity and mortality	Provides skilled newborn and postpartum care, including: • recognizing complications in the newborn and postpartum woman and providing appropriate management • promoting health and preventing disease in the woman, including: – provision of iron/folate and tetanus toxoid – vitamin A and iodine in areas of deficiencies – encouraging use of impregnated bednets for the woman and newborn in areas of malaria prevalence – provision of contraceptive counseling and services • promoting health and preventing disease in the newborn, including: – thermal protection – promotion of breastfeeding – eye care – cord care – vaccinations • providing appropriate counseling and education for the woman and family about danger signs and self-care for the postpartum woman and newborn • informing woman and family of existence of emergency funds • referring to higher levels of care when appropriate Supports the community s/he serves Respects community's expectations and works within that setting Educates community about complication readiness Promotes concept of and dispels misconceptions and harmful practices that could prevent complication readiness

COMMUNITY	FAMILY	WOMAN
Advocates and facilitates preparedness and readiness actions.	*Supports pregnant woman's plans during pregnancy, childbirth and the postpartum period.*	*Prepares for birth, values and seeks skilled care during pregnancy, childbirth and the postpartum period.*
Supports and values women's use of postpartum and newborn care Supports and values use of skilled provider during postpartum period Supports appropriate and healthy norms for women and newborns during the postpartum period Makes sure that the woman is not alone during the postpartum period Recognizes danger signs and supports implementing the Complication Readiness Plan Supports mother- and baby-friendly decision-making in case of newborn emergencies Supports timely transportation of woman and newborn to referral site, if needed Has a functional blood donor system Can access facility and community emergency funds Dialogues and works together with provider on expectations Supports the facility that serves the community Educates community members about complication readiness Advocates for policies to support skilled healthcare Promotes concept of and dispels misconceptions and harmful practices that could prevent complication readiness	Advocates for skilled healthcare for woman Supports the woman's use of postpartum and newborn care, adjusts responsibilities to allow her attendance Recognizes complication signs and facilitates implementing the Complication Readiness Plan Agrees with woman on decision-making process in case of postpartum or newborn emergency Knows transportation systems, where to go in case of emergency, and support persons to stay with family Supports provider, woman and newborn in reaching referral site, if needed Knows how to access community and facility emergency funds Has personal savings for costs associated with postpartum and newborn care Purchases drugs or supplies needed for normal or emergency postpartum and newborn care Knows how and when to access community blood donor system Identifies blood donor	Seeks postpartum and newborn care at least twice—at 6 days and at 6 weeks postpartum (obtains money, transport) Recognizes danger signs and implements the Complication Readiness Plan Speaks out and acts on behalf of her and her child's health, safety and survival Knows transportation systems, where to go in case of emergency, and support persons to stay with family Can access community and facility emergency funds Has personal savings and can access in case of need

Appendix B

MNH Program Publications and Resources, 1998–2003

REPORTS AND BOOKS

- *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood*, with the ENABLE Project (October 2003)
- *Shaping Policy for Maternal and Newborn Health: A Compendium of Case Studies,* with Saving Newborn Lives and Family Care International (October 2003)
- *Close-Out Report: Bolivia* (August 2003)
- *Building a Global Movement: The White Ribbon Alliance for Safe Motherhood, 1999-2003,* with NGO Networks for Health (May 2003)
- *Scaling Up Practices, Tools, and Approaches in the Maternal and Neonatal Health Program* (May 2003)
- *Using Performance and Quality Improvement to Strengthen Skilled Attendance* (February 2003)
- *A Summary of Findings from Baseline Surveys in Three Maternal and Neonatal Health Program Countries* (December 2002)
- *Close-Out Report: Peru* (October 2002)
- *The Maternal and Neonatal Health Program: Building a Legacy for Improved Maternal and Newborn Care—A Review to Date* (January 2002)
- *Implementing Global Maternal and Neonatal Health Standards of Care,* English and Spanish (2001)

JOURNAL ARTICLES

- Sirima SB et al. 2003. "Failure of a Chloroquine Chemoprophylaxis Program to Adequately Prevent Malaria during Pregnancy in Koupéla District, Burkina Faso," *Clinical Infectious Diseases* 36, no. 11 (June): 1374.
- Sanghvi HC, B Kinzie, and M McCormick. 2002. "Reducing Postpartum Hemorrhage: Routine Use of Active Management of the Third Stage of Labor," in *Making Childbirth Safer Through Promoting Evidence-Based Care.* Washington, DC: Global Health Council.
- Perreira KM et al. 2002. "Increasing Awareness of Danger Signs in Pregnancy through Community- and Clinic-Based Education in Guatemala," *Maternal and Child Health Journal* 6, no. 1 (March): 19-28. Supported writing for results of MotherCare research.
- McCormick ML, HCG Sanghvi, B Kinzie, and N McIntosh. 2002. "Preventing Postpartum Hemorrhage in Low-Resource Settings," *International Journal of Gynecology & Obstetrics* 77, no. 3 (July): 267-275.

- Program for Appropriate Technology in Health. 2001. "Preventing Postpartum Hemorrhage: Managing the Third Stage of Labor." *Outlook* 19, no. 3 (September): 1–8. (Also in French and Spanish) Developed as a collaboration between PATH and MNH Program.
- Johnson R. 2001. "Implementing Global Standards of Maternal and Neonatal Healthcare at the Provider Level: A Strategy for Disseminating and Using Guidelines." JHPIEGO Strategy Paper no. 10. Baltimore, MD: JHPIEGO.
- Child Health Research Project. 1999. *Reducing Perinatal and Neonatal Mortality: A Special Report.*

REFERENCE MANUALS AND LEARNING MATERIALS

- *Malaria during Pregnancy Resource Package: Tools to Facilitate Policy Change and Implementation* (October 2003)
- *Emergency Obstetric Care: Quick Reference Guide for Frontline Providers* (September 2003)
- *Learning Resource Package for Managing Complications in Pregnancy and Childbirth: Guide for Teachers* (2002)
- *Guidelines for Technical Adaptation and Translation of Managing Complications in Pregnancy and Childbirth* (2001)
- World Health Organization (WHO). 2000. *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors.* Geneva: WHO. Provided technical assistance for development and publication.
- *Basic Maternal and Newborn Care* (forthcoming).
- *Managing Newborn Problems* (forthcoming from WHO). Provided technical assistance for development and publication.

INFORMATION SHEETS

Best Practices

- The Partograph: An Essential Tool for Decision-Making during Labor (9/02)
- Competency-Based Training: A "Learning by Doing" Approach (9/02)
- Informed Demand for Safe Motherhood (6/02)
- Postabortion Care: Skilled Care and Comprehensive Services (4/02)
- Preventing and Treating Malaria during Pregnancy (3/02)
- Detecting and Treating Newborn Asphyxia (3/02)
- Preventing Postpartum Hemorrhage: Active Management of the Third Stage of Labor (also in Spanish) (3/02)
- Developing Experts for Maternal and Neonatal Health (1/02)

- The Traditional Birth Attendant: Linking Communities and Services (1/02)
- Woman-Centered Care (1/02)
- Detection and Management of Hypertensive Disorders of Pregnancy (12/01)
- Mother-to-Child Transmission of HIV/AIDS: Reducing the Risk (11/01)
- Performance and Quality Improvement (also in French) (10/01)
- Addressing Gender in Maternal and Newborn Healthcare (10/01)
- Focused Antenatal Care: Planning and Providing Care during Pregnancy (also in French) (9/01)
- Newborn Health (6/01)
- The Skilled Provider: A Key Player in Saving the Lives of Women and Newborns (also in Spanish) (6/01)

Technical Area Profiles

- Social Mobilization through Collective Action for Safe Motherhood (also in French) (12/01)
- Behavior Change Interventions (also in Spanish) (5/01)
- Maternal and Neonatal Health (MNH) Program (Overview) (also in Spanish) (5/01)
- Monitoring and Evaluation (also in Spanish) (5/01)
- Policy and Finance (also in Spanish) (5/01)
- Service Delivery (also in Spanish) (5/01)

Making A Difference

- Ambassador of Quality: An Interview with Sylvia Deganus (1/02)
- Change Agents in Bangladesh, Uganda and Uruguay: Extending beyond MNH Program Countries (1/02)
- An Ambitious Agenda: Regional Expert Responds to Call for Training in Burkina Faso (also in French) (1/02)
- Nurse and Ob/Gyn Work to Improve Women's Healthcare Practices in Guatemala (1/02)
- Beyond the Call of Duty: Midwives Work to Improve Care in Ugandan Hospitals (10/01)

Country Profiles

- Nepal (1/02)
- Zambia (1/02)
- Bolivia (also in Spanish) (6/01)
- Burkina Faso (also in French) (6/01)
- Guatemala (also Spanish) (6/01)
- Honduras (also in Spanish) (6/01)

- Indonesia (6/01)
- Tanzania (6/01)

Program Highlights, Case Studies, and News

- White Ribbon Alliance Launch in Burkina Faso Wins International Recognition (6/02)
- Adapting Performance and Quality Improvement at the Community Level: The Burkina Faso Experience (3/02)
- MNH Program Participates in Indonesian Media Campaign to Encourage Shared Responsibility for Safe Motherhood (3/02)
- National Seminar Addresses Causes of Maternal Mortality in Indonesia (3/02)
- Guatemalan Woman Survives Childbirth with the Help of Community-Based Life-Saving Plan (also in Spanish) (2/02)
- Guatemala Ministerial Agreement Will Scale Up Performance and Quality Improvement Initiative (2/02)
- Implementing a Performance and Quality Improvement Approach at the Country Level (also in Spanish) (2/02)
- Bolivia Issues Ministerial Resolution Officially Mandating Evidence-Based Maternal and Newborn Healthcare Practices (also in Spanish) (1/02)
- Guatemala's Clinical Skills Training Fosters New Practices and Attitudes (1/02)
- Changing Facility-Based Practices: Experiences from Burkina Faso, Nepal and Guatemala (also in French and Spanish) (1/02)
- Guatemala: Developing and Implementing Community-Based Life-Saving Plans (1/02)
- Country Activities (also in French and Spanish) (12/01)
- Promoting Focused Antenatal Care at the Country Level (also in French) (12/01)
- Honduras: Developing and implementing hospital-based epidemiologic surveillance system for MNH (11/01)
- Guatemala District Conducts First Forum on Safe Motherhood (11/01)
- Social Mobilization in the Maternal and Neonatal Health Program: Global and Country Activities
- Simple Approaches Save Newborns in Respiratory Distress (10/01)
- Helping Families Worldwide (also in Spanish) (6/01)

OTHER PUBLICATIONS AND RESOURCES

- *MNH Program Expert Trainer Directory: Latin America and the Caribbean* (also in Spanish) (2002)
- *MNH Program Expert Trainer Directory: Africa* (2001)
- *Birth Preparedness/Complication Readiness: A Matrix of Shared Responsibility* (also in French and Spanish) (2001)
- *White Ribbon Alliance for Safe Motherhood. Awareness, Mobilization, and Action for Safe Motherhood: A Field Guide*. 2000. Washington, DC: White Ribbon Alliance for Safe Motherhood. Supported publication in English and translation into French and Spanish.
- *MNH Update*, a monthly newsletter about MNH Program activities
- MNH Program Website: http://www.mnh.jhpiego.org/